New Clerk Training Manual
School-Based Health Services Program
2009- 2010 School Year

September 2009

VERMONT
DEPARTMENT OF EDUCATION

Special Education Finance
(802) 828-5111

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INTRODUCTION

The Medicaid School Based Health Services Program is used by the State to generate Medicaid reimbursement for medically related services provided to eligible students. Each school district can only submit claims for the students for which the district serves as the local education agency under the federal special education law (IDEIA) and is fiscally responsible. This includes students that are tuitioned by the school district to another school district whether in or out of the state of Vermont.

ELIGIBILITY FOR SCHOOL-BASED HEALTH SERVICES

In order to submit Medicaid claims, a supervisory union must determine which of its students are eligible under the School-Based Health Services Program. For a student to be eligible they must:

- be a Special Education student
- have a valid IEP
- be enrolled in Medicaid

SCHOOL-BASED HEALTH SERVICES PROGRAM ELIGIBILITY

Each supervisory union needs to develop a process that identifies which special education student's are enrolled in Medicaid.

- Check eligibility of all special education student's that move into the supervisory union
- Check eligibility of all student's being evaluated for special education services

The Medicaid field representative will assist in determining eligibility by:

- Requesting a caseload list in the fall
  - Each student on the list will be checked for Medicaid eligibility
  - A list of eligible students will be provided to the supervisory union
- Review Child Count, which is due to the Department of Education mid-December
  - Each student on the Child Count list will be checked for Medicaid eligibility
  - A list of eligible students will be provided to the supervisory union

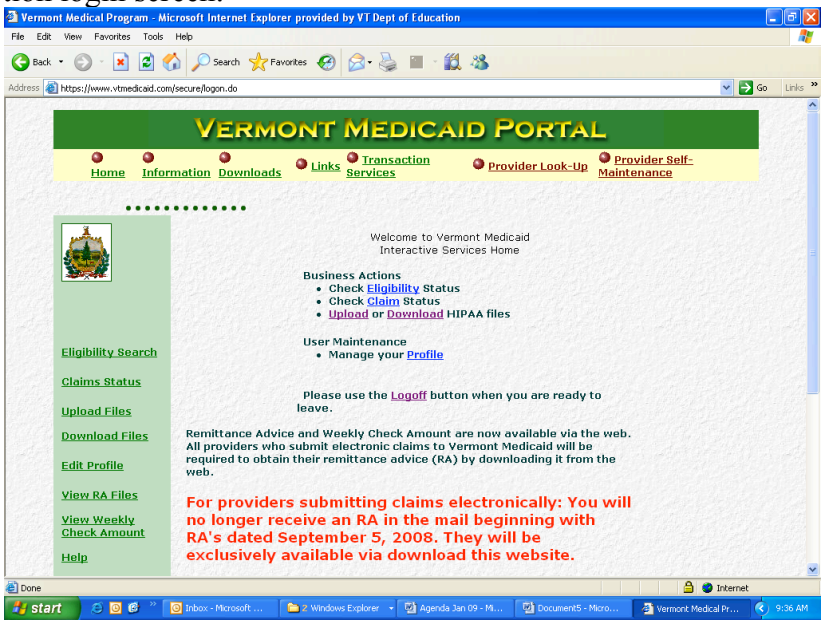
CHECKING MEDICAID ELIGIBILITY

There are several methods that can be used to check eligibility.

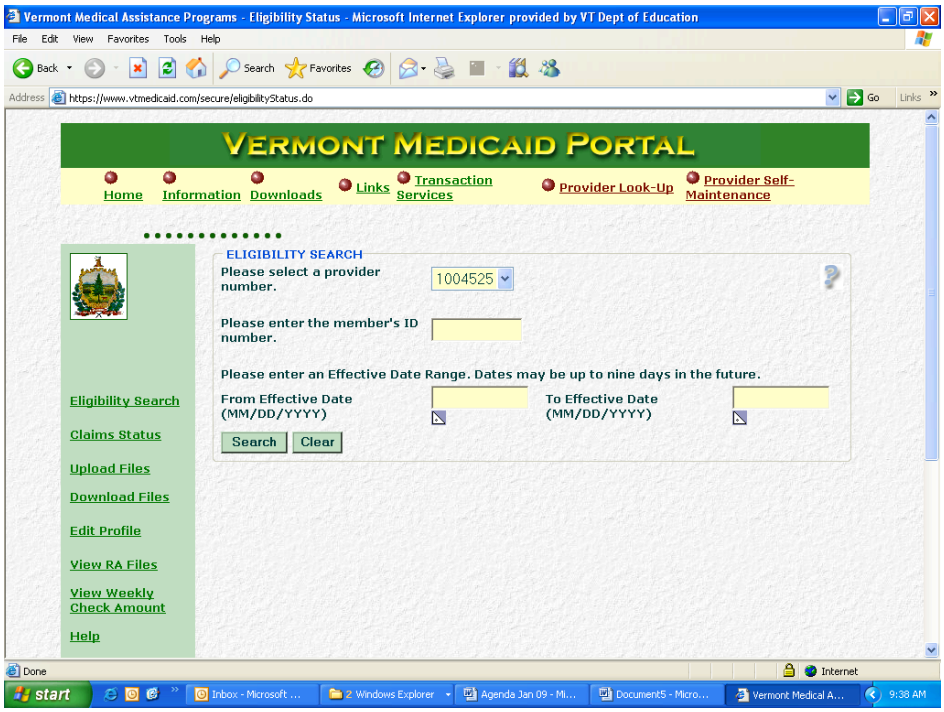
- Contact your Medicaid field representative. You will need to have:
  - Student's name
  - Student's date of birth
- Check electronically on www.vtmedicaid.com (can only use this if you have the student's social security number)

HOW TO CHECK MEDICAID ELIGIBILITY ELECTRONICALLY

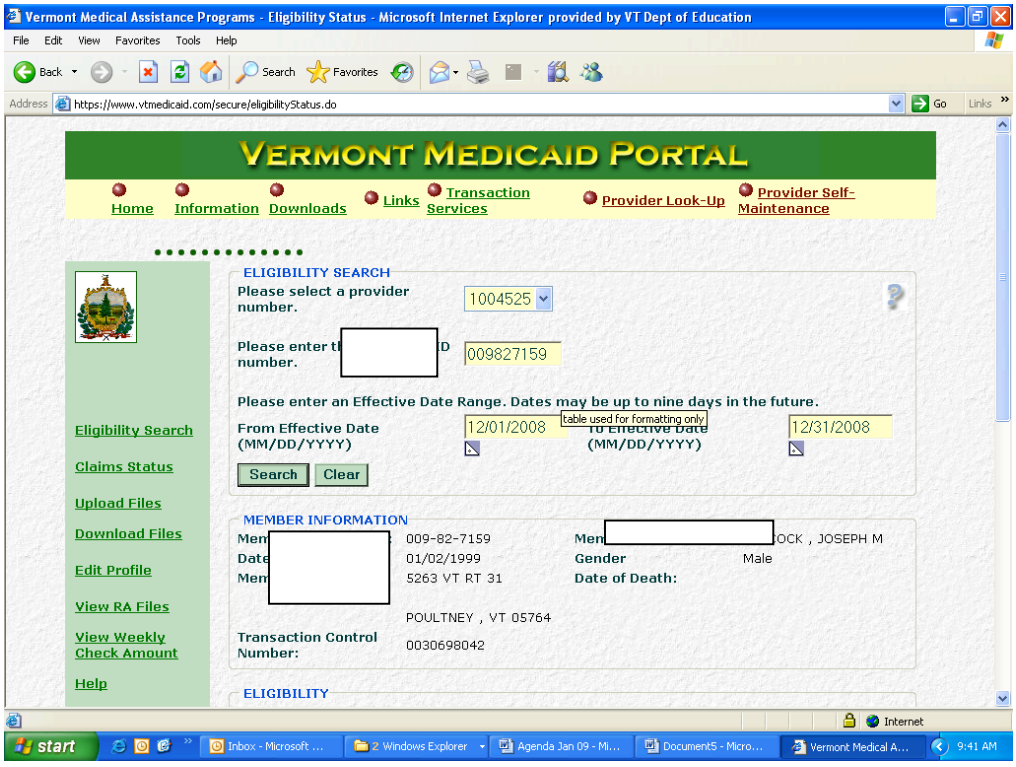
From the production login screen:



Click Eligibility Search



Type the social security number and the eligibility dates you would like to review. EDS recommends checking eligibility for a specific day or month.



From this screen you can review eligibility and the individuals current Primary Care Physician.

RELEASE OF INFORMATION (ROI)

When a student is found eligible for special education services as well as Medicaid services, you will need to obtain release of information. There are 3 different types of forms:

- Parental/Guardian Release
    - There is a letter as well as a ROI form that is sent to the parents for signature. They have the option to authorize or not authorize billing of services to Medicaid.
    - If the student's parents have joint custody, you will need to obtain ROI from both parents.
- 18 year old/legal guardian
    - If a child that is still in school turns 18, he/she will need to sign their own ROI. As of this age, they are their own guardian. If a child was state placed and turned 18, they will also need to sign their own ROI.
- Child in DCF custody
    - There is a blanket form for any child that is in DCF custody. You will need to take a blank copy and put the following information on it.
        - The date that you are putting it in the child's file.
        - Student's SSN
        - Student's name
        - Student's date of birth

There are multiple ways to obtain the ROI form.

- Medicaid clerk sending directly to the parent/guardian with a copy of the form letter that is provided
- The Case Manager can request this form at the IEP meeting
- If the child came from another district, then the Medicaid clerk can ask the other Supervisory Union to see if there was a ROI on file. The ROI's can be transferred from SU to SU provided that it not SU specific.

You will only have to get a ROI one time unless one of the following happen:

- The student has a name change
- The student's guardianship changes (adoption, DCF custody…)
- The student turns 18 becoming their own legal guardian

Date stamp the ROI form when it is received. You can not bill PRIOR to the date that the form was signed.

PHYSICIAN AUTHORIZATION

A Release of Information must be obtained before a Physician Authorization can be requested. The form can be signed by a physician, doctor of osteopathic medicine, a physician's assistant or a nurse practitioner.

HOW TO FIND THE STUDENT'S PHYSICIAN:

- Listed on the Release of Information form
- Check the www.vtmedicaid.com website, under eligibility
- Contact the Case Manager or School Nurse
- Contact your field representative

HOW TO FIND THE PHYSICIAN'S ADDRESS:

- Go to the www.vtmedicaid.com website, choose the option *Provider Look-up,* enter the name of the physician you are searching for and click enter. The address and other pertinent information will appear.
- There may be labels or a database in the office with frequently used physician's addresses.

HOW TO FILL OUT THE FORM:

- Complete the header information, best practice is to have the from and through dates match the initiation and duration dates of the IEP (the dates cannot exceed one year).
- The time for each category of billable service is totaled and listed on the corresponding line of the physician authorization form.
- If the IEP is amended during the year a new authorization is needed if there is an increase in services being billed. If there is a decrease in services a new authorization is not required.
- If the IEP dates only include the school year and an amendment is done to include summer services a new physician authorization is required. If the IEP was for a full calendar year and included the summer service or indicated that appropriate summer services would be determined later, the physician authorization for the original IEP serves as the authorization. The only exception is if the physician specifically excluded the summer services from the authorization.

WHAT TO SEND TO THE PHYSICIAN:

- Completed physician authorization form
- Physician Authorization Letter
- IEP cover and service page
- Self-addressed, stamped envelope

As you work with the physicians in your area you will become familiar with what paperwork they require. Some do not require the physician letter or the IEP, whereas some physicians want to have a copy of the physician letter, the complete IEP and a copy of the most recent evaluation.

WHAT TO DO WHEN THE AUTHORIZATION IS RETURNED:

- Best practice is to date stamp the form when it is received at the supervisory union office.
- The authorization should be reviewed to make sure the physician signed the form and to ascertain if the physician made any notations that would affect the services to be billed or the time period covered by the authorization form.
- The form must be placed in the student's Medicaid file.

CONSULTING PHYSICIAN

Some supervisory unions choose to use a consulting physician to sign their Physician Authorization forms. Parents have the right to refuse the use of this physician and can insist that only their child's physician review their child's records.

HAND CHANGES

There may be instances when an error is noticed on the Physician Authorization form after it is printed. The following are the methods that can be used to correct errors:

- If a form is completed electronically and the clerk realizes that a change to either a date or a service needs to be made PRIOR to sending the form to the physician, it needs to be corrected electronically and reprinted.
- If a form is completed electronically and the clerk realizes that a change to either a date or a service needs to be made AFTER being signed by the physician, the clerk can either reprint and resubmit the form for signature or call the physician and obtain telephone permission for the changes and note the date the physician approved the changes.
- If a form is completed by hand and a change is needed, the change should be initialed by the clerk if made prior to sending to the physician.
- If a form is completed by hand and a change is needed after the physician has signed, obtain telephone permission for the changes and note the date the physician approved the changes.
- If a physician makes a change to the Physician Authorization form, the change must be initialed by the physician. If the physician does not initial the change, the clerk needs to obtain telephone permission, and note the date the physician approved the changes.

PHYSICIAN AUTHORIZATION FORM

Student Name: Thomas Jones

Date of Birth: 12/25/1992

Primary Educational Disability: Speech & Language Impaired

Physician: Marcus Welby

Please return to:

Vermont Supervisory Union

Elm Street

Montpelier, VT 05620

Health related services included in this child's IEP for one year from 06/07/02 through 06/07/03.

	Services	**How Long**	**How Often**
_____	Developmental & Assistive Therapy (Services provided in order to promote normal development by correcting deficits in the child's affective, cognitive and psychomotor/fine motor skills development. Services include the application of techniques and methods designed to overcome disabilities, improve cognitive skills and modify behavior.)	_____	_____
_____	Medical Consultation	_____	_____
_____	Mental Health Counseling	_____	_____
_____	Nutrition Services	_____	_____
X	Occupational Therapy	30 min	2 x's/wk
_____	Personal Care	_____	_____
_____	Physical Therapy	_____	_____
_____	Rehabilitative Nursing Services	_____	_____
X	Speech, Hearing & Language Services	60 min	2 x's/wk
_____	Vision Care Services	_____	_____

I have reviewed these health-related services and certify that they are medically necessary.

Marcus Welby _____ 6/13/02 _____

Physician's Signature Date

Primary Medical Diagnosis (optional): Speech and Language Impaired

Revised: July 2006 Date Received by Supervisory Union:_____

PROVIDER CERTIFICATION/AGREEMENT/REASSIGNMENT OF PAYMENT

Medicaid requires providers whose services are billed at the professional level sign a Provider Certification Agreement relinquishing their right to bill Medicaid directly for services provided in accordance with an IEP.

To complete the Provider Certification,

- The professional staff member enters their name and title
- Check the professional category under which they qualify
- Provide a valid license to the Medicaid clerk
- Complete Section A if you have a Medicaid Provider Number
- Complete Section B if you are a school employee
- Sign and date the form

Once the Provider Certification is signed and dated the Supervisory Union Superintendent, Special Educator Director, Principal or designee will sign and date the form below the signature.

This form is signed only once unless the provider has a name change. Once the clerk has this information on file, it is their responsibility to contact Human Resources to update the licenses as they expire.

The SLP would include a copy of their current state license and a copy of their Certificate of Clinical Competence (CCC) or equivalent documentation to bill at the professional level:

- A current Certificate of Clinical Competence from the American Speech and Hearing Association
- An expired Certificate of Clinical Competence
- A State of Vermont Clinical SLP license and proof of the clinical fellowship year or documentation that the clinical fellowship year is being completed.
    - The State of Vermont Clinical license is sufficient proof of the clinical fellowship year **if** the individual received their first SLP license after 10/1/04

All providers who do not fall into one of the above categories can not bill as a professional. Paraprofessionals must be supervised by a SLP who meets the above criteria.

When a SLP develops a plan to deliver the IEP services and trains a paraprofessional on how to administer the services, the SLP is considered by Medicaid to be supervising the services and therefore accountable for the services provided.

ENDORSEMENT CODES

The Dept of Education issues educator licenses. Licenses include two codes. The first code is the instructional level. The second two-digit code is the endorsement. The following endorsement codes are considered professional providers for Developmental and Assistive Therapy and Case Management: 67, 68, 80, 81, 82, 84, 85, 86, 87

IEP & EVALUATION CLAIMS

Supervisory unions are able to bill for the case management services involved in the development of subsequent IEPs and evaluations for Medicaid eligible recipients ages three to 22. A child's initial evaluation or IEP is not eligible for reimbursement

A Release of Information must be on file before an IEP or Eval claim can be submitted.

Claims for 3-Year Special Education Reevaluation (Pink Form)
Supervisory unions can submit Medicaid claims for 3-year special education reevaluations. It is suggested that this form be printed on pink paper. Reimbursement for this service is limited to once every 910-day period.

Claims for Annual IEP (Blue Form)
Supervisory unions can submit Medicaid claims for IEP development after the initial IEP. It is suggested that this form be printed on blue paper. The reimbursement for this service is limited to two in a 275-day period.

Completing an IEP or Reevaluation Claim form
The case manager needs to complete the following information on the claim form **in ink**:

1. All student information needs to be completed, such as: student's name, SS#, etc.
2. Check the appropriate box to indicate the type of IEP or Evaluation.
3. The process dates for the evaluation or IEP must be completed.
4. At least six activities must be checked, and the eligibility decision must be indicated on the evaluation claim form.
5. Sign, print name and date (mm/dd/yy) the form and submit to their Medicaid clerk.

QUESTIONS AND ANSWERS

If a student is found ineligible for special education and then is later found eligible again, is the evaluation considered an initial evaluation?

Yes, when a child is found eligible for special education and they are not on an IEP at the time of the eligibility determination, the evaluation is considered to be an initial evaluation. This is true even if they had received special education services at some point in the past.

If a student is found ineligible for special education, is the reevaluation that found the student ineligible able to be billed to Medicaid?

Yes, when a child is found eligible for special education and then later found ineligible during a reevaluation, the reevaluation that found the student ineligible is billable.

If a child moves to Vermont from another state and has been receiving special education services in the sending state, can we bill the first Vermont evaluation that is done for that child?

No, the first evaluation that is done in Vermont for a student is considered an initial evaluation even if the child has already had an evaluation in another state.

Can I bill for a Supplemental Evaluation?

No, you may only submit one pink (reevaluation) form every 910 days.

Can I bill for a form 8?

No, a form 8 is not eligible for reimbursement.

If a child moves to Vermont from another state and brings an IEP from the sending state, can a supervisory union bill the new Vermont IEP that is written for that child?

No, the first IEP that is written in Vermont for a student is not billable. This initial Vermont IEP cannot be billed as the federal government required that this service not be billed as part of Vermont's Medicaid rate negotiations.

How many IEPs can be submitted in a year?

Only two IEP's (blue forms) can be submitted in a 275-day period.

Can I bill for an amended IEP?

No, effective for billing dates 9/1/09 or later.

DOCUMENTATION LOGS

Documentation is required for each service that is provided. There are four different types of documentation logs:

- Case Management Assurance form
- Developmental and Assistive Therapy log
- Personal Care Documentation log
- Related Services Documentation log

CLERK DOC LOG RESPONSIBILITIES

- All header information is completed
- Developmental and Assistive Therapy log—the IEP Activity matches the IEP Service Description
- Developmental and Assistive Therapy log —each log contains only one IEP service performed by one provider
- Case Management Assurance form—the IEP initiation/amendment date matches the IEP
- Case Management Assurance form —the hours per week/month match the IEP for each IEP/amendment
- Case Management Assurance form —the from and to dates do not exceed the dates billed on the LOC
- Related Services log—there is a complete date, service description, group size and time for each service
- Related Services log—the service description is adequate
- Personal Care log—calendar includes time not X's
- Personal Care log—only one log per student, unless there are two full-time personal care aides
- Total hours must match the documentation
- If the documentation indicates services on a snow day/vacation/weekend etc… the clerk can only bill for services provided when school was in session. Best practice is to place a note in the margin of the documentation log indicating the amount of time that will be billed on the LOC
- The documentation log is completed in ink and does not include white-out. Logs containing white out or completed in pencil need to be photocopied or the clerk needs to obtain a new log
- Hand changes to the documentation log need to be initialed where appropriate
- The provider has signed and dated the log
- The provider listed in the header is the individual signing as provider
- A professional has signed and dated the log where applicable
- The professional's printed name appears on the log where applicable and matches the name of the individual who signed as professional
- For logs signed electronically, the provider's printed name, date and submitted electronically check box are completed electronically
- All documentation logs are completed on the correct version of the form

PROGRESS NOTES

Progress notes are required for all related services billed to the School Based Health Services Program. Progress notes need to be completed quarterly or to coincide with the school marking period. If progress notes are not completed, future billing for the service can not be submitted.

DOCUMENTATION LOG CHANGES

The following documents indicate who can complete/change information on the documentation logs.

Color of Cell	Who Can Make Changes.
	Medicaid Clerk, Case Manager, Provider--Can enter information into the cell before the log is signed and can modify information after the log is signed.
	Provider NOTE--if information is changed after the form is signed, the change must be initialed.
	Medicaid Clerk, Case Manager, Provider--Can enter information into the cell before the log is signed. Only the provider can modify information after the log is signed. NOTE--if information is changed after the form is signed, the change must be initialed.

In addition--While it is acceptable to make changes as indicated above, all changes must be reasonable. For example--The Medicaid clerk has the ability to modify the student information on the documentation logs. This does not mean that the Medicaid clerk can change the student's name on the log from Jimmy Smith to Bobby Brown (unless the student's name has actually changed from Jimmy Smith to Bobby Brown). Another example--If a documentation log states "Math" and the IEP service states "Reading", the Medicaid clerk could not change the service on the documentation log to match the IEP as Math and Reading are two different services.

Case Management Assurance

Student Information

Name: Date of Birth (mm/dd/yy)

Diagnostic Code:

Provider Information

Provider Name: Name of School:

Supervisory Union Name :

IEP Services Provided

Enter below the initiation date of the student's IEP and the number of hours per week listed on that IEP for Case Management Services:

IEP Initiation/Amendment Date	IEP Hours Per Week (indicate if service is monthly)

Billing Period Assurance

This assurance covers the following dates for the billing period:

From:	
To:	

I assure that I provided the following number of hours of case management during this billing period.	_____Hours

Provider Signature: _____ **Date**: _____

Developmental & Assistive Therapy Service Documentation Log

Student Information

Name: **Date of Birth (Mo/Day/Year):**

Diagnostic Code:

Provider Information

Provider Name: **Provider Title:**

Supervisory Union: **Name of School:**

IEP Service:

List the service being provided as it appears on the IEP. Add hours per week based on the IEP.

IEP Activity	Individual or Group	Minutes Per Session	Sessions Per Week	Hours Per Week

Developmental & Assistive Therapy service listed above was provided to this student as shown in the calendar below:

Service Dates: The numbered boxes below reflect the days of the month. Enter month and year for the month(s) of billing period. Mark an "X" for each day that the Developmental and Assistive Therapy service was provided for the minutes indicated in the IEP as a session. **If the minutes per session or group size are different then what is listed in the IEP, the actual minutes per session or group size should be indicated on the calendar**. For services provided in groups, only include those provided in Medicaid billable group size. For professionals, the group size must be six or less students and for paraprofessionals, the group size must be four or less students.
DO NOT USE PENCIL OR WHITE OUT.

Month								Year						
								Use this set of dates for a two-month billing period						
1	2	3	4	5	6	7		1	2	3	4	5	6	7
8	9	10	11	12	13	14		8	9	10	11	12	13	14
15	16	17	18	19	20	21		15	16	17	18	19	20	21
22	23	24	25	26	27	28		22	23	24	25	26	27	28
29	30	31						29	30	31				

Indicate the total number of hours of billable service provided during the billing period:	1:1 Service	Hours
	Small Group	Hours

Provider Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____

Personal Care Service Documentation Log

Student Information

Name: _____ **Date of Birth (Mo/Day/Year):** _____

Diagnostic Code: _____

Personal Care Hours Per Week: _____ **Does the student receive 1:1 services during their entire school week?** _____

Provider Information

Provider Name: **Provider Title:**

Supervisory Union: **Name of School:**

The student's current IEP requires full-time 1:1 personal care services.

Service Dates: The numbered boxes below reflect the days of the month. **Write the number of hours personal care was provided in the corresponding date box. DO NOT USE PENCIL OR WHITE OUT.**

Month								Year						
Use this set of dates for a two-month billing period														
1	2	3	4	5	6	7		1	2	3	4	5	6	7
8	9	10	11	12	13	14		8	9	10	11	12	13	14
15	16	17	18	19	20	21		15	16	17	18	19	20	21
22	23	24	25	26	27	28		22	23	24	25	26	27	28
29	30	31						29	30	31				

Total hours personal care was provided during the billing period _____ **hours**

Service Type: The 1:1 personal care support for this student includes the following activities. Check all that apply (at least one of the 1 through 9 activities must be checked in order to be considered personal care).

1. ☐ **Assistance w/Eating**
2. ☐ **Assistance w/Toileting**
3. ☐ **Assistance w/Dressing**
4. ☐ **Assistance w/Hygiene**
5. ☐ **Behavior Management**
6. ☐ **Signing/Interpreting**
7. ☐ **Medication Admin.**
8. ☐ **Mobility/Safety**
9. ☐ **Assistive Devices**
10. ☐ **Other:** _____

_____

_____

Provider Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____

Related Services Documentation Log

For professional services including PT, OT, Speech, Language & Hearing, Vision, Nutrition, Mental Health Counseling, Rehabilitative Nursing Services.

Not for use with Developmental and Assistive Therapy or Personal Care Services.

STUDENT INFORMATION	**PROVIDER INFORMATION**
Name: **Date of Birth:** **Diagnostic Code:**	**Provider Name:** **Provider Type:** **SU/School:**

Date mm/dd/yy	**Activity/Procedure/Service Brief Description**	**Small Group Or Individual**	**Minutes Per Session**

Group size must be six or less students for professional services or four or less students for paraprofessional services in order to be a Medicaid billable service. Use additional pages as necessary. **DO NOT USE DITTO MARKS, ARROWS, PENCIL or WHITE OUT**.

Actual hours of 1:1 services provided during the billing period	_____ **hours**
Actual hours of small group services provided during the billing period	_____ **hours**

Quarterly progress note to be completed on the back of this form.

Provider Signature: _____ **Date:** _____

Title: _____

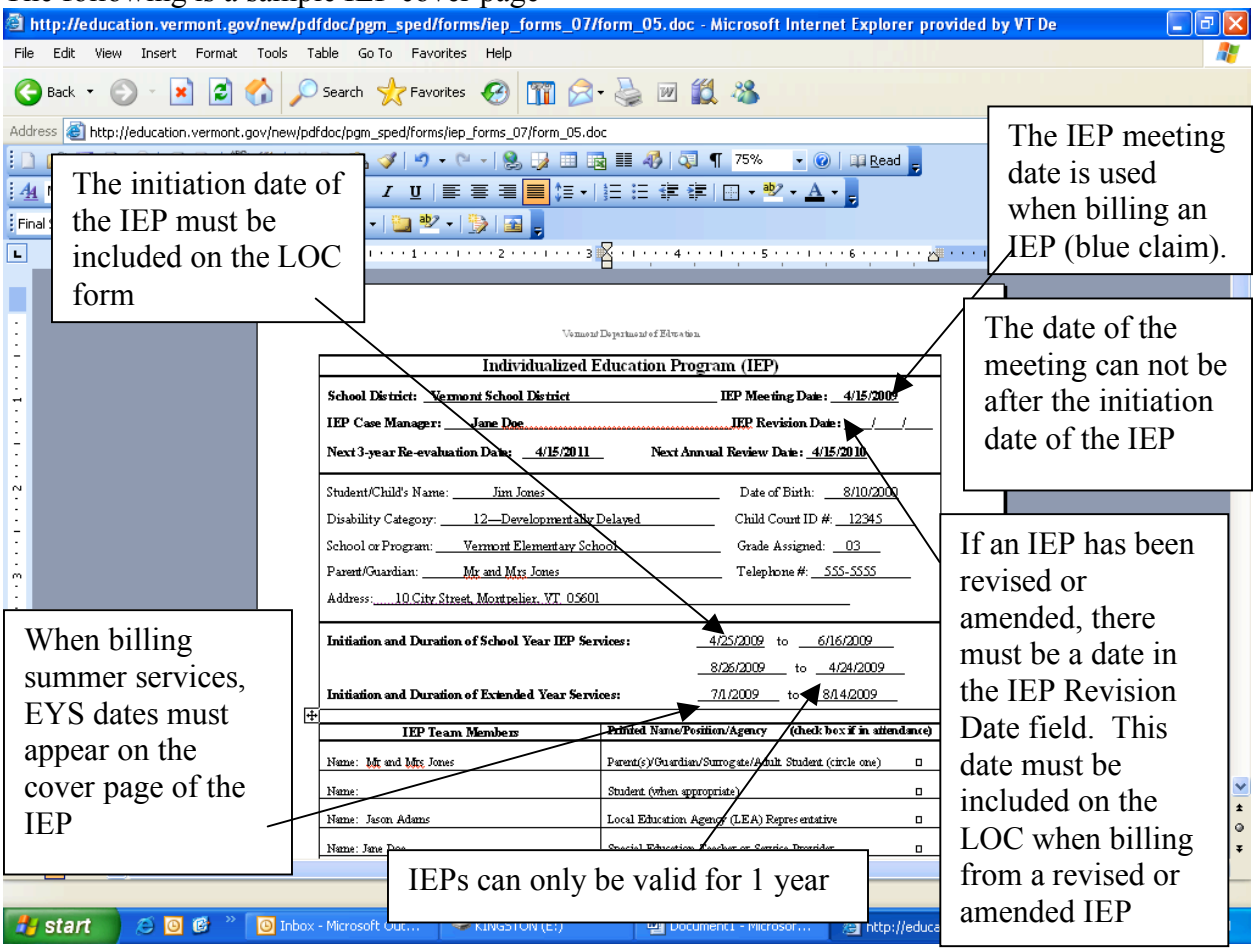
Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____

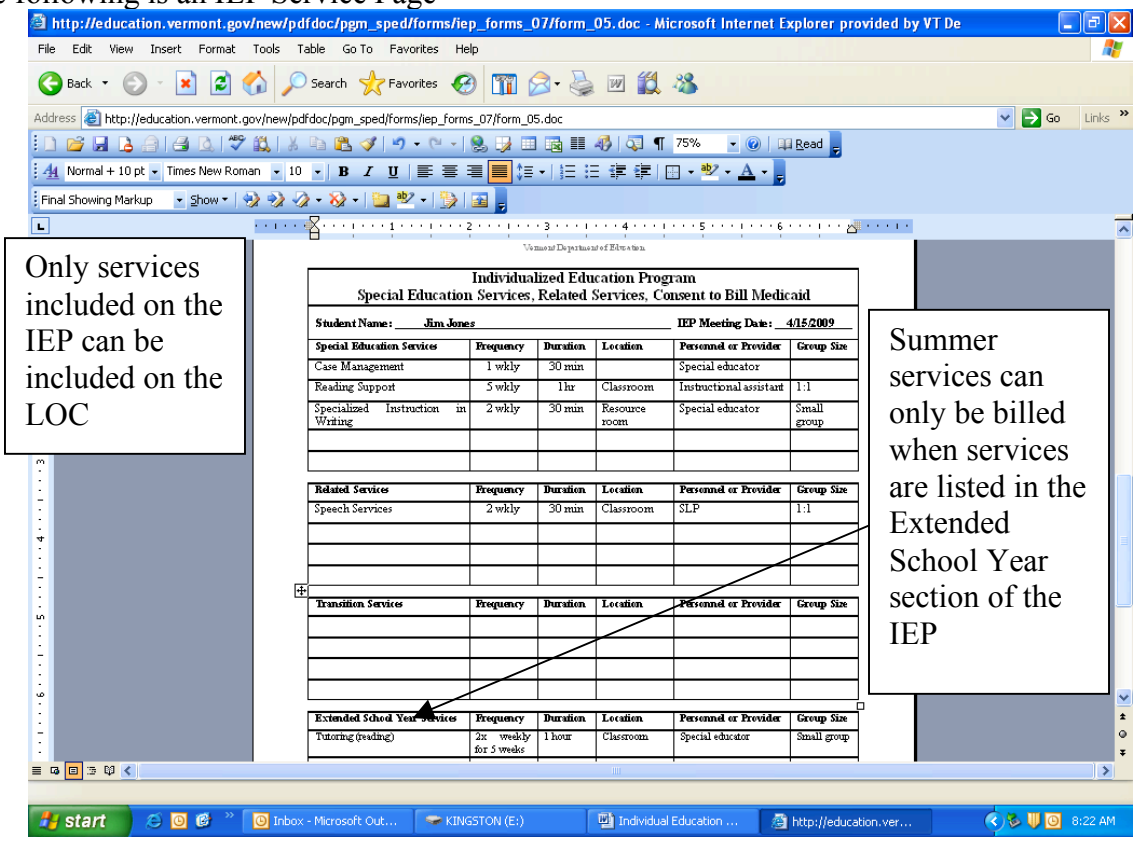
INDIVIDUAL EDUCATION PLAN (IEP)

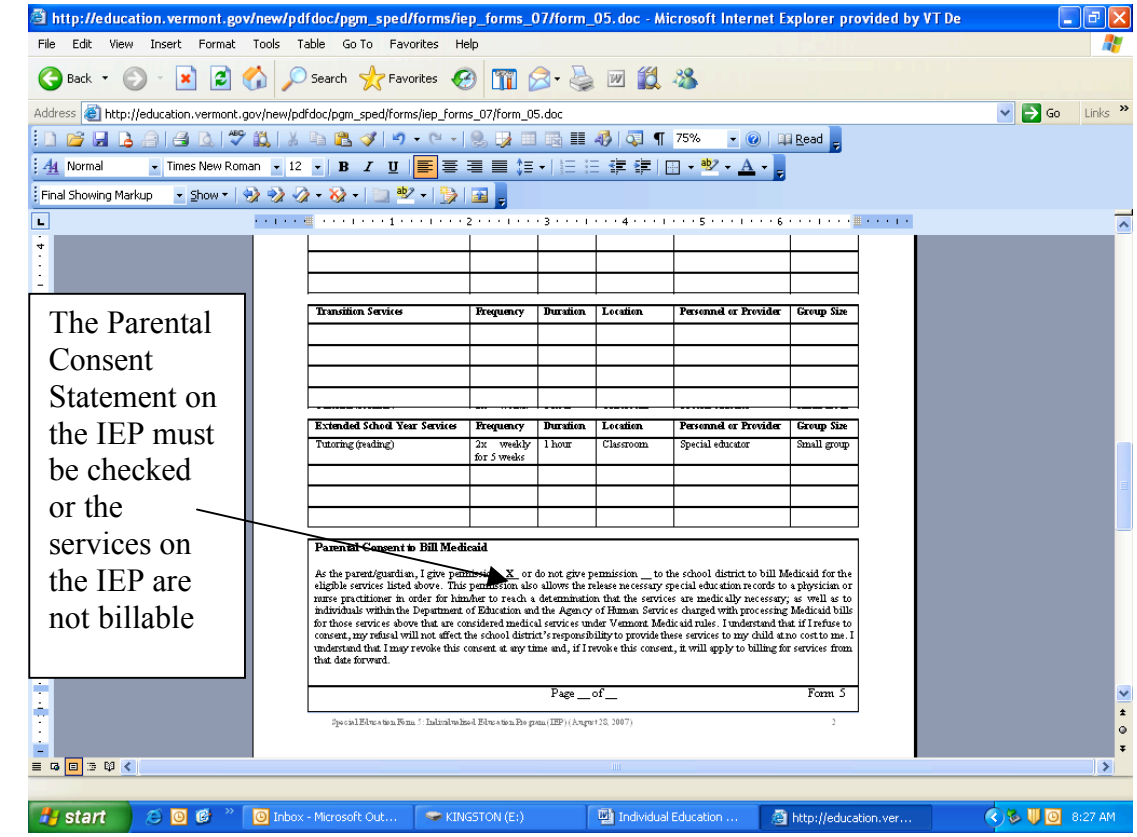
An Individual Education Plan (IEP) is the document that outlines the special education services that a child will receive. This document acts as a contract between the parent and the school. IEPs are valid for up to one year. Only services included on an IEP can be billed to Medicaid.

The following is a sample IEP cover page



The following is an IEP Service Page





IEP AMENDMENTS AND CORRECTIONS

What is an IEP amendment?
An IEP amendment is defined as a change to an IEP based on the child's need. When an IEP is amended a form 5b, form 7a or SpedDoc Amendment page must be produced. Amendments must clearly indicate the changes and when the changes are effective.

What paperwork needs to be on file for an amended IEP?
When an IEP is amended a copy of form 5b, form 7a or the SpedDoc Amendment page must be on file clearly indicating the effective date of the amendment. A copy of the amended service and cover page must be attached to form 5b, form 7a or the SpedDoc Amendment form.

What is a correction to an IEP?
A correction to an IEP can be made when information was omitted or typed incorrectly on the IEP form. A correction is effective the date services were initiated. The case manager must contact the parent prior to making a correction on an IEP. If the parent has the same understanding as the case manager then the IEP can be corrected and redistributed. If the parent does not agree the amendment process would need to be followed.

What paperwork needs to be on file for a correction to an IEP?
If a corrected copy of the IEP is produced by the case manager, then the original IEP should be removed from the Medicaid file.

What action is needed when the consent paragraph on the IEP is not checked?
The IEP correction process described above should be followed. This correction is effective the date the IEP is initiated.

Can the Medicaid clerk make a change to the IEP if the case manager tells them to?
No, the Medicaid clerk can never make a change, handwritten or electronically, to an IEP. It is the case manager's responsibility to make corrections to the IEP

BILLABLE SERVICES

In order for a service to be billable under the School-Based Health Services Program, the student must be receiving services identified in the State Medicaid Plan in accordance with his or her IEP. Please refer to the manual for complete descriptions on each billable service.

- Assessment and Evaluation
- Medical Consultation
- Durable Medical Equipment
- Vision Care Services
- Nutrition Services
- Physical Therapy (PT)
- Speech, Hearing and Language Services (SLP)
- Occupational therapy (OT)
- Mental Health Counseling
- Rehabilitative Nursing Services
- Developmental and Assistive Therapy
- Personal Care
- Case Management

IEP WORDING

Only services required by the IEP are billable to Medicaid. **The IEP must list for each service: the provider type, frequency, duration and group size**.

If the service description, provider type, frequency, duration or group size is left blank the service is **not billable**. Each of these fields on the IEP must be completed in order for the service to be billable to Medicaid.

The Use of Ranges and the Words And/Or--Medicaid only allows the lowest amount of service required by the IEP to be billed. This means that if the provider, frequency, duration or group size is listed as a range, only the lowest amount required can be billed.

> **Example**: if the IEP states speech and language by a SLP, 60 minutes a week, 1:1/small group, the service can only be billed on the LOC as small group service, even if the service was provided one-on-one.
>
> **Example:** when the IEP states reading with a special educator or paraprofessional, two times a week for 30-45 minutes a session, 1:1 or small group, the service can only be billed as paraprofessional for 60 minutes small group, even if the service was provided by a special educator for 90 minutes one-on-one.

Access to, Up to, Available, As Needed--Some IEP services are not billable to Medicaid due to the wording on the IEP. When words such as: available, access to, up to, as needed etc. are used on the IEP a specific amount of time is not required and therefore not billable to Medicaid.

> **Example:** The IEP states "adult available to assist as needed". The IEP does not require a specific service or amount of time, only that someone be available to the student. Since the student may or may not utilize the adult's assistance, there is no billable service.
>
> **Example:** The IEP states "individual aide, 5x a week, up to 6 hours per day". As the IEP does not state an amount of time that the service must be provided, the service is not billable.

EXCLUSIONS FROM SCHOOL-BASED HEALTH SERVICES BILLING

The following services, regardless of what they are called, have been determined to be ineligible for Medicaid funding for **all** programs including the School-Based Health Services program:

Art Therapy
Dance Therapy
Facilitated Communication
Horseback Riding
Movement Therapy
Music Therapy
Sensory Integration Therapy
Swimming
Neurodevelopmental Treatment (NDT)
Visual Training Therapy
Vocational Services (see below for more detail)

The following are non-billable for the School-Based Health Services Program:

Services provided to incarcerated individuals
Large Group Services
Missed Services due to student refusal
Transportation

The following services are excluded from billing under the School-Based Health Services program as some of the services may be claimed under the EPSDT program or paid for by Title 1 funds.

Guidance Counseling
Routine School Health Services
Title 1 Services (for the time the provider is paid by Title 1 Funds)
Services provided under a Success Beyond Six contract

The following is a list of some of the service descriptions that may be used on IEPs which fall under the general category of Vocational Services:

Career Exploration
Job Training
½ day at Tech Center
Vocational Training

- Automotive
- Carpentry
- Construction
- Culinary Arts
- Hairdressing
- Woodworking

If the child needs support from a paraprofessional for 100% of the school day, the paraprofessional's time is billable as personal care, **regardless of the setting**. If the child receives support for less than 100% of the school day, the paraprofessional's time may meet the criteria for developmental and assistive therapy, **regardless of the setting**.

This means that even if the student is receiving a non-covered service, such as a vocational service, the paraprofessional's time is allowable if the paraprofessional is performing personal

care services. For developmental and assistive therapy, the paraprofessional's time could be billed if the service he/she is providing is covered by the developmental and assistive therapy definition (example-behavior modification).

When billing Developmental and Assistive Therapy or Personal Care in an excluded setting, the IEP activity must specify that the service provided is for behavior, safety, mobility, communication, reading support etc…

SERVICE DESCRIPTIONS NEEDING FURTHER CLARIFICATION

General academic services are non-covered by the School-Based Health Services Program. If any of these services are listed on the IEP, a person who knows the details of what is being provided, such as the case manager, special educator or special education director needs to determine whether the services are billable. Services needing further clarification include, but are not limited to:

Academic Support	Structured Study Hall
Life Skills	Supervised Study Hall
Organizational Skills	Supported Study Hall
Social Skills	Transition
Study Skills	Tutorial

DEVELOPMENTAL AND ASSISTIVE THERAPY CHECKLIST

The following questions are designed as a guide to assist in determining when a service is billable as Developmental and Assistive Therapy. The exception is that services listed as "Exclusions from School-Based Health Services Billing" are **never** billable.

Case Manager's Name:_____

School:_____

Student's Name:_____

IEP Initiation Date:_____

Service in Question:_____

Yes___	No___	Is the service identified by the IEP along with the duration and frequency that the service will be provided?
Yes___	No___	Is specialized instruction being provided to the student? For example, if the service is listed as "study hall" does it actually involve someone providing specialized instruction to the student or is instruction only provided when a student requests assistance?
Yes___	No___	Does the service promote normal development by correcting deficits in the child's affective, cognitive, behavioral or psychomotor/fine motor skills?
Yes___	No___	Is the service provided by a licensed special educator or under the direction of a licensed special educator?

Case Manager's Signature:_____

Date:_____

If the answer to all of the above questions is "Yes", and the appropriate documentation is in place, the service is billable as Developmental and Assistive Therapy. If any of the above answers are "No", the service does not qualify for reimbursement.

LEVEL OF CARE BILLING

PRE-BILLING CHECK LIST

In order for a student's IEP services to be billed through the LOC claims process, all of the following must be in place.

- Verify the student is enrolled in Medicaid
- Obtain Release of Information Form signed by the current legal guardian (parent, court appointed legal guardian(s), 18 year old student or blanket DCF consent)
- Verify that the legal guardian has "given permission" on the IEP to bill Medicaid.
- Obtain physician authorization for the IEP services being provided.
- Maintain a current copy of the IEP cover page and service page in the students' Medicaid file
- Obtain a signed Provider Certification Form and copy of licenses/appropriate documentation from all professionals working with the student whose services are Medicaid billable or an Out-Of-District Provider Certification Agreement.
- Obtain documentation (including progress notes where applicable) for each service billed on the LOC form.

LOC BILLING PERIODS

There are nine possible billing periods during the year

- Extended School Year – July/August (summer services)
- August/September – 1st day of school to 9/30
- October – 10/1 - 10/31
- November – 11/1 – 11/30
- December/January – 12/1 – 1/31
- February – 2/1 – end of February
- March – 3/1 – 3/31
- April – 4/1 - 4/30
- May/June – 5/1 – last day of school

HOW TO COMPLETE THE LOC

- Complete all of the header information
- Include the IEP initiation date and any amendment dates that cover the period being billed
- From date of service – is the actual beginning date of service for that student
    - For most students it is the day the billing period begins
    - If a student moves into the school district – it is the day the student started
    - If the IEP/physician authorization starts mid-month – it is the day the IEP/physician authorization starts
- To date of service – is the actual ending date of service for that student
    - For most students it is the last day of the billing period
    - If a student moves – it is the last day the student was in school
    - If an IEP/physician authorization ends mid-month – it is the last day the IEP/physician authorization is valid.
- School days – the number of days in the billing period for that school/school district (See below)
- Provider type – use the drop down box to select if professional or para-professional

    - Special educators on an emergency or provisional license must bill developmental and assistive services at a paraprofessional license. Case management can be billed at the professional level.
- Group size – select 1:1 or group
    - Group size if provided by a professional is 2-6 students
    - Group size if provided by a paraprofessional is 2-4
- Medicaid service category – use the drop down box to select the category
- Description – this is an optional column
    - Best practice is to match the service being billed to the IEP and documentation log.
- Hours provided for the billing period – this is based on the number of hours noted on the documentation log(s).
    - Medicaid clerk should verify the total hours noted match the time provided based on the calendar or documentation log
    - Correct math where appropriate
    - Hours billed on the LOC do not included services provided on days school was not in session
    - When entering the hours of service on the LOC form, use the decimal equivalent to convert the minutes into hours
- Billable hours per week – this column is automatically calculated based on the hours provided for the billing period and the number of school days in the billing period.
- Hours per week (from IEP) – this is an optional field
    - Best practice is to enter the hours per week allowed by the IEP for each service that is being billed.
    - If this column is filled in, the LOC will not let you bill more than the IEP states
- Hours per month (from IEP) – this is an optional field
    - Best practice is to enter the hours per month (for a monthly service) allowed by the IEP for each service that is being billed.
    - If this column is filled in, the LOC will not let you bill more than the IEP states
- When using a mid-month LOC
    - The number school days each IEP covers is entered into the IEP1 and IEP 2 school day box
    - The number of hours per week or hours per month from each IEP for each service is enter to the appropriate box
    - The actual hours provided for each service for each IEP is entered into the appropriate box
    - All of the case management hours provided need to be added to the actual hours provided box under IEP 1.
- Units/Calculation of LOC
    - The LOC will automatically calculate the number of units and assign a level of care
    - Units in excess of 42 are entered as outliers
- Outlier Units
    - If the total units is over 42.00, each .5 unit or higher can be billed as an outlier (rounding rules apply)
    - A partial unit of .5 or more can be billed a one outlier unit
    - A partial unit less than .5 can not be billed
- Notes – this section of the LOC is only used when submitting case management claims (See below).

- Signature – after the LOC is completed the Medicaid clerk needs to sign and date the LOC.
- Payment information – this is an optional section
    - Best practice – enter the date the claim was submitted to EDS. This can be beneficial if you are trying to track claims
    - Best practice – enter the date of the RA that the claim shows as paid. This can be beneficial if you need to retrieve an ICN number when doing an adjustment to the claim or recouping the claim

SCHOOL DAYS

The number of school days = the number of student school days in the billing period

- This may vary with school districts
- For a student placed outside of the school district – use the calendar of the school where the student is receiving services
    - If a case management only claim – use the LEA calendar
- EEE students – the number of school days is based on the elementary school calendar in the school district the student resides
- In-service days, snow days, school closings, etc **do not** count as a school day
- A missed day due to student/provider absence does count as a school day
- The number of school days is always determined based on the number of school days in the entire billing period, even if the student exited or entered the district part way through the billing period.

CASE MANAGEMENT ONLY CLAIMS

In order for a case management only claim to be billed, there must be an IEP service being billed to Medicaid by another agency.

Four rules for billing a case management only claim:

- A school employee must actually be providing case management to the student during the billing period
    - This does not include coordinating and developing the IEP or Evaluation process
- Medicaid is being billed for an IEP service through another agency
- In the note section of the LOC you must enter:
    - Name of the agency or organization that is directly billing Medicaid
    - The IEP service being billed to Medicaid
- Calculate the school days based on the local education agency calendar

SUMMER SERVICES

In order to bill for summer services (ESY services), the services must be included in the IEP. For each IEP service being billed, the IEP must include a:

- Service description
- Frequency
- Duration
- Group size
- Provider type

The extended school year dates must also be listed on the cover page or the service page of the IEP.

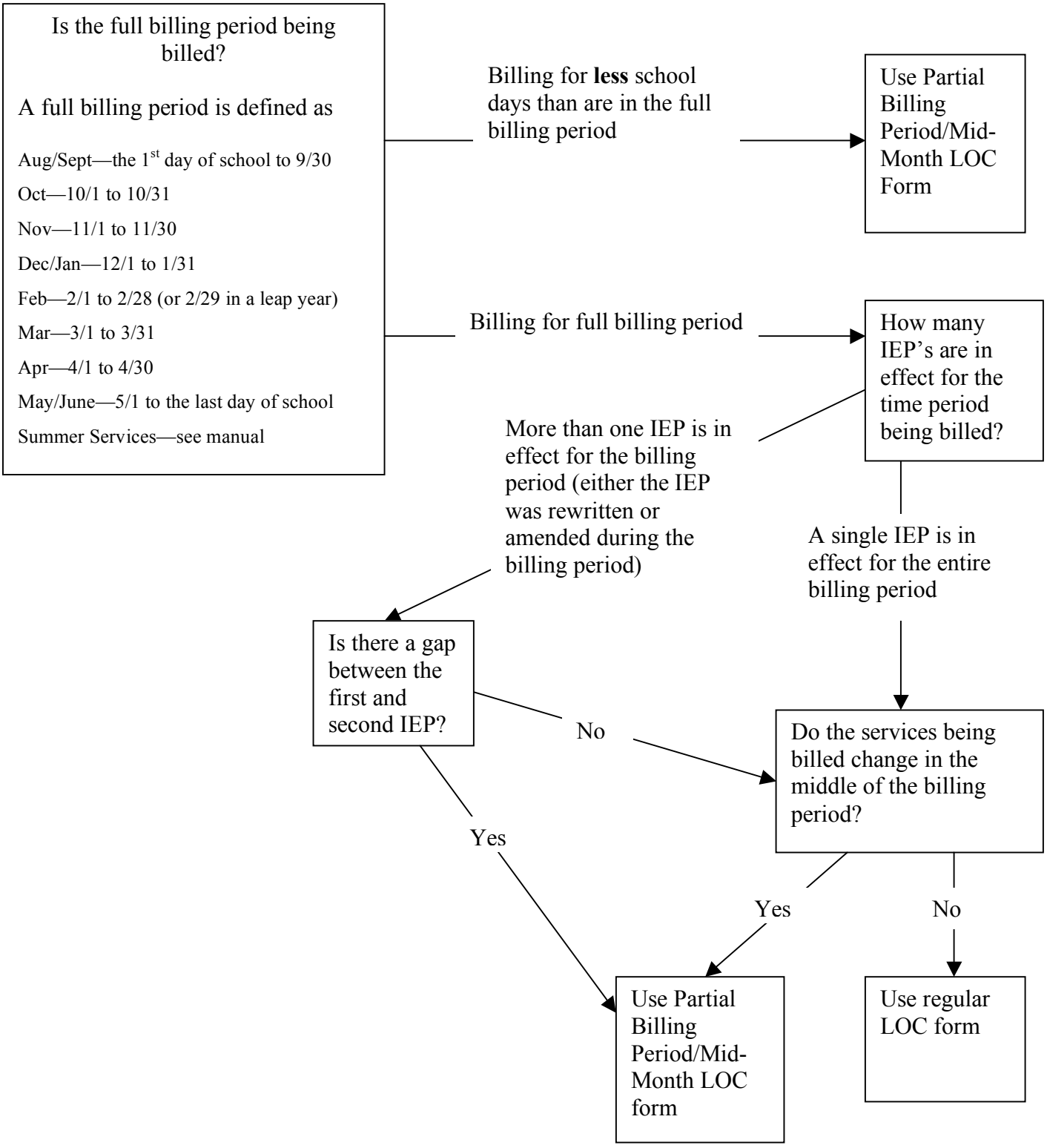
There are only two allowed billing periods for summer services:

- A four-week period (20 school days)
- A six-week period (29 school days)

If the services being provided are different or more than the services provided during the school year, you will need to obtain a new Physician Authorization.

See the manual for instructions on billing summer service. Contact your Medicaid field representative for assistance in billing summer services.

How to Determine Which LOC Form to Use

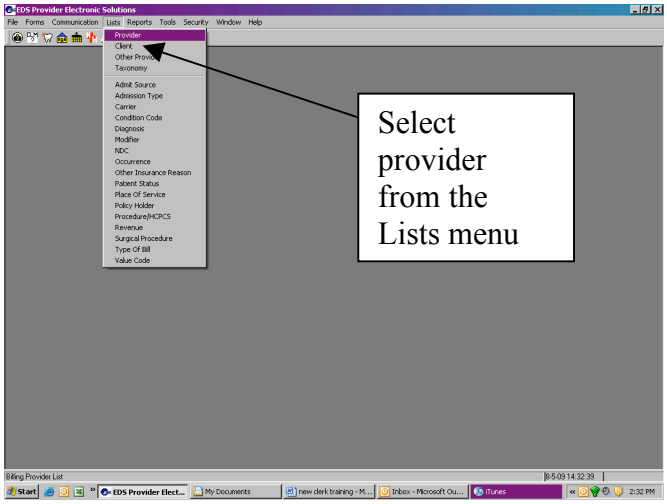


ELECTRONIC CLAIM SUBMISSION

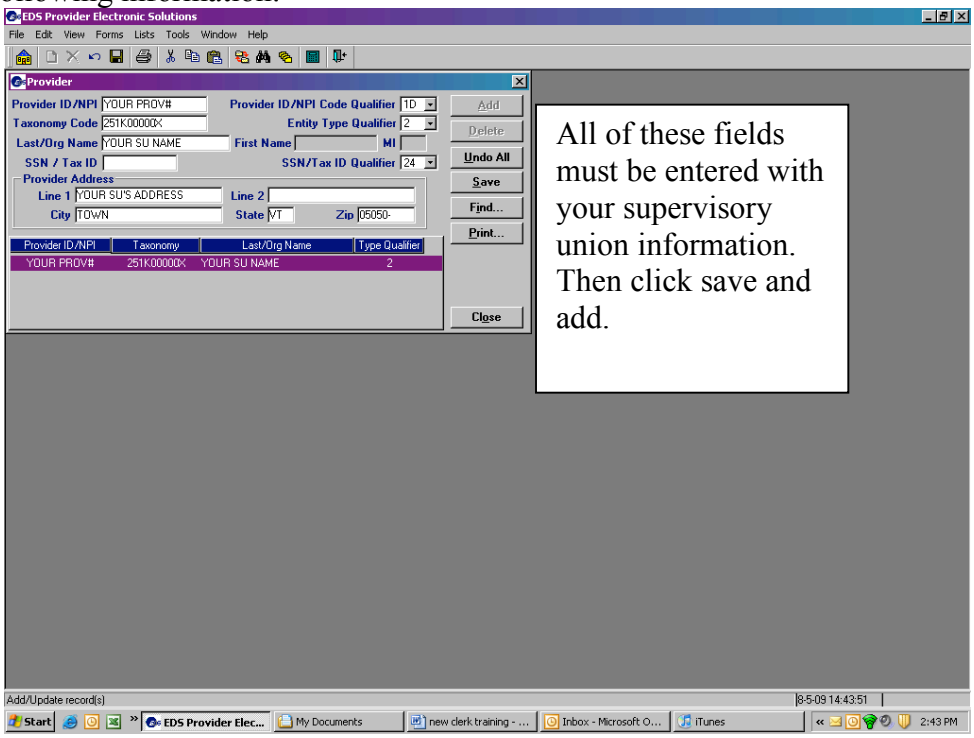
Claims are submitted through the Medicaid billing software. There are a number of steps that need to be taken prior to electronically submitting a claim.

- Create a provider list
- Create a client list
- Create a procedure code list (optional)
- Create a modifier list (optional)
- Create a diagnosis code list (optional)

HOW TO CREATE A PROVIDER LIST

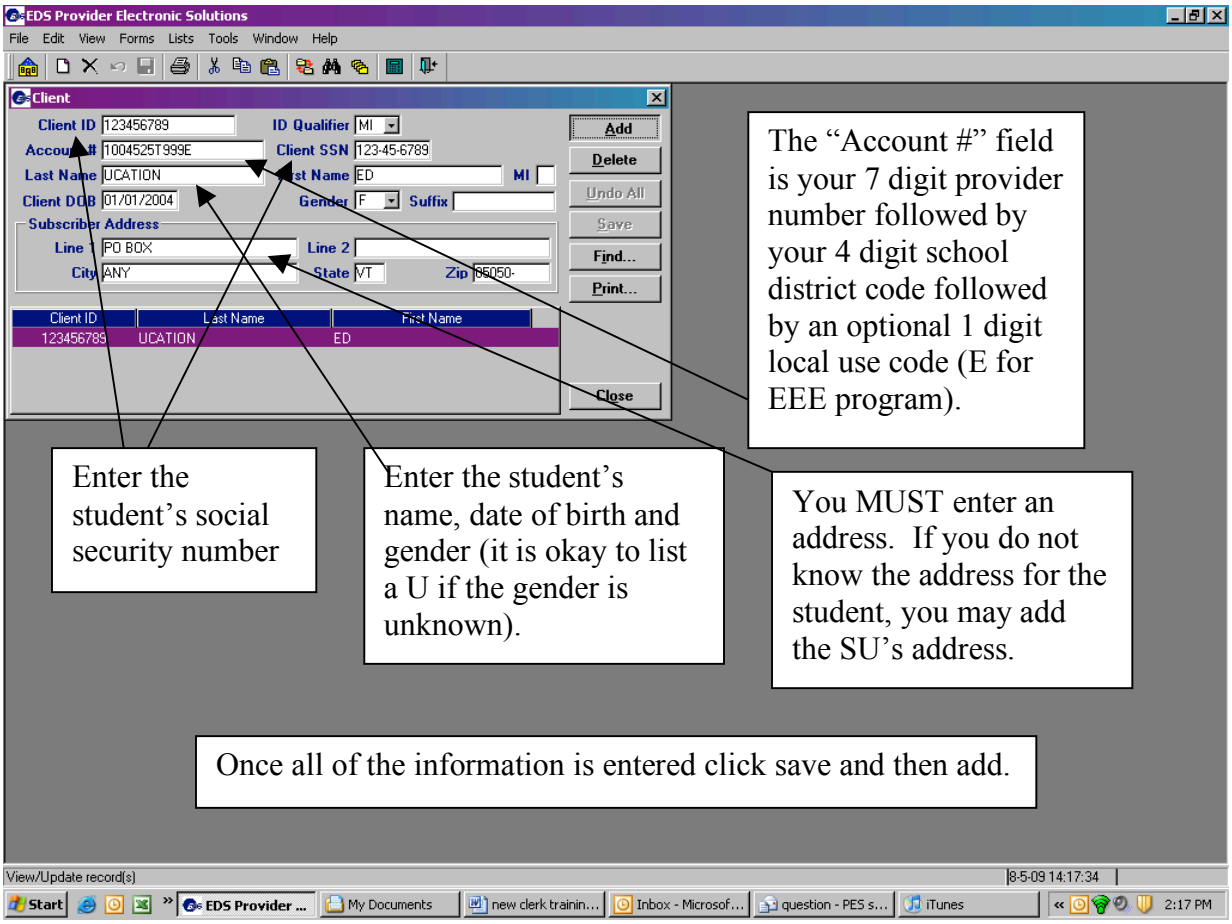


Enter the following information:



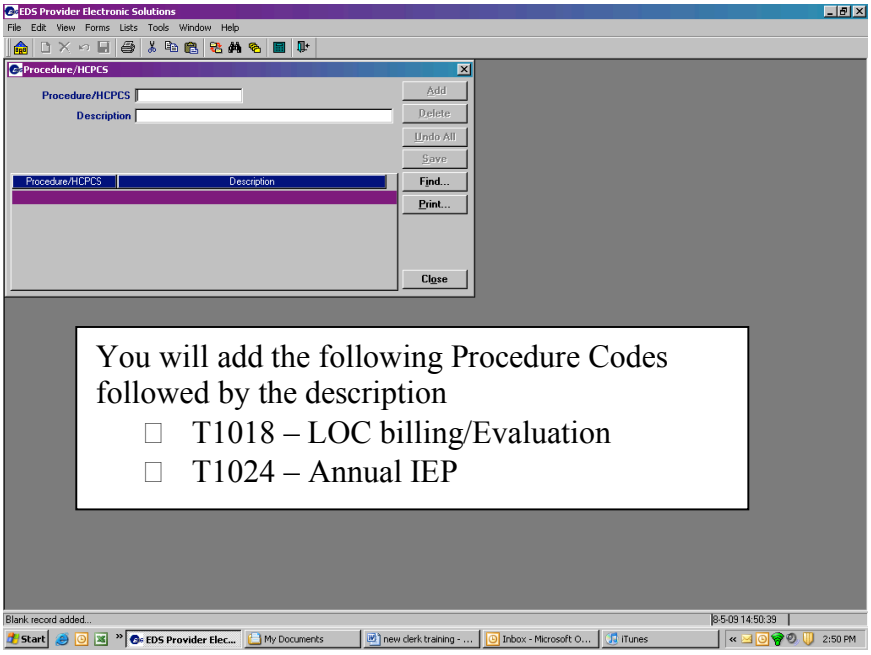
HOW TO CREATE A CLIENT LIST

Select "Client" from the Lists menu



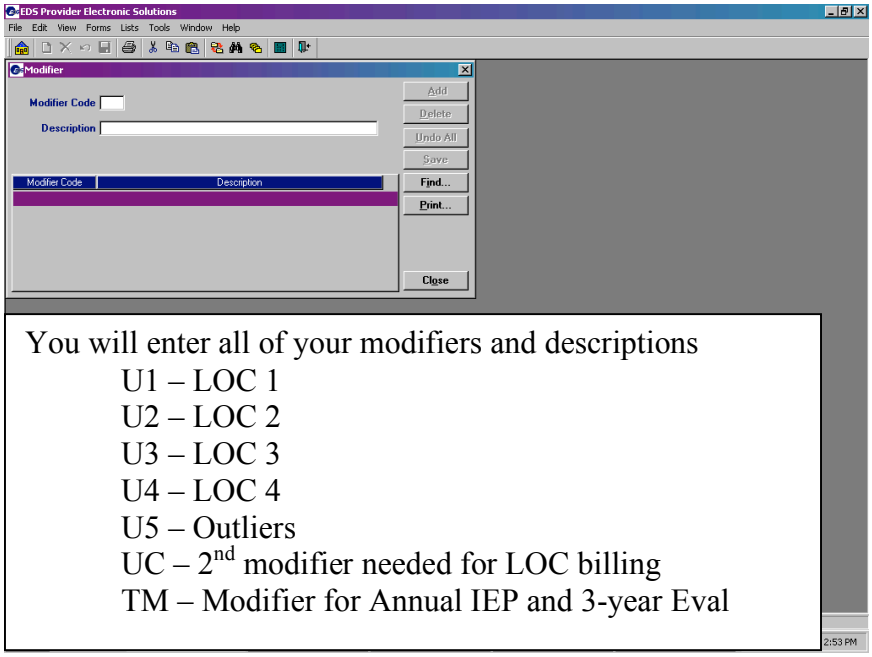
HOW TO CREATE A PROCEDURE LIST

Select "Procedure/HCPCS" from the Lists menu



HOW TO CREATE A MODIFIER LIST

Select “Modifier” from the Lists menu

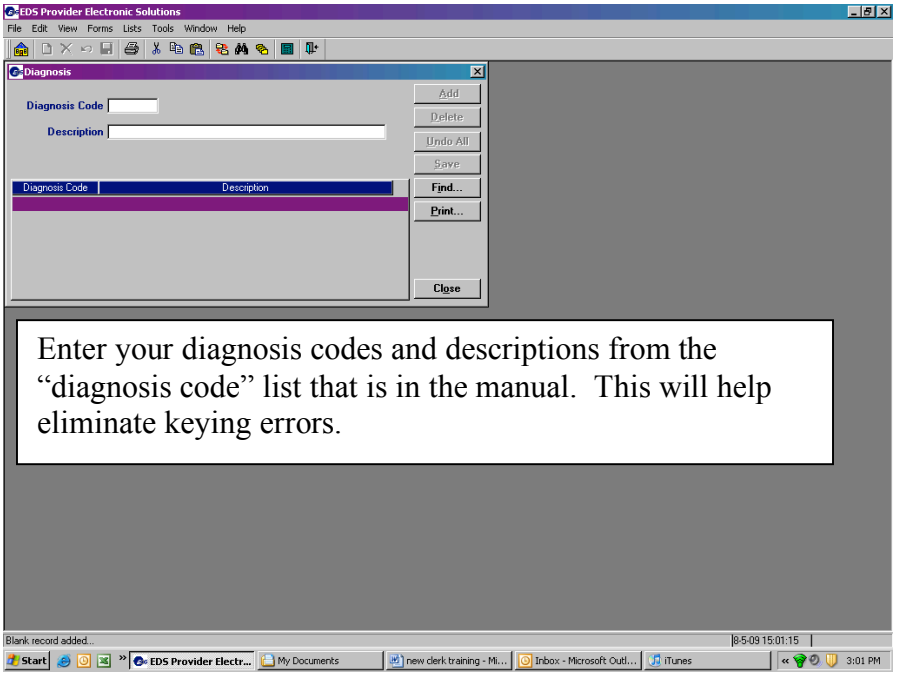


You will enter all of your modifiers and descriptions

- U1 – LOC 1
- U2 – LOC 2
- U3 – LOC 3
- U4 – LOC 4
- U5 – Outliers
- UC – 2nd modifier needed for LOC billing
- TM – Modifier for Annual IEP and 3-year Eval

HOW TO CREATE A DIAGNOSIS LIST

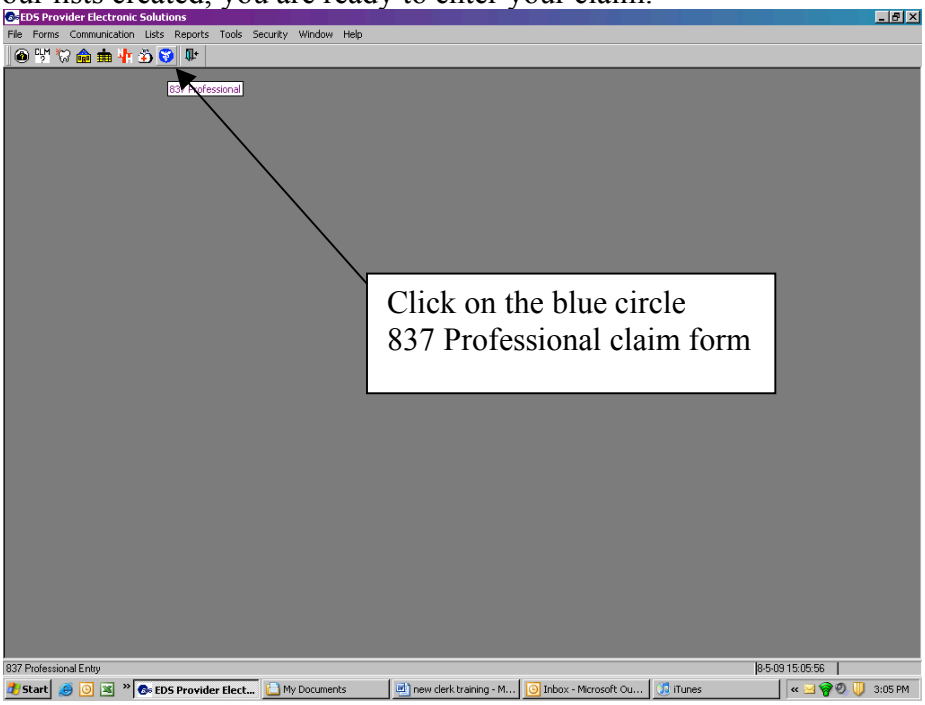
Select “Diagnosis” from the Lists menu Select “Modifier” from the Lists menu



Enter your diagnosis codes and descriptions from the “diagnosis code” list that is in the manual. This will help eliminate keying errors.

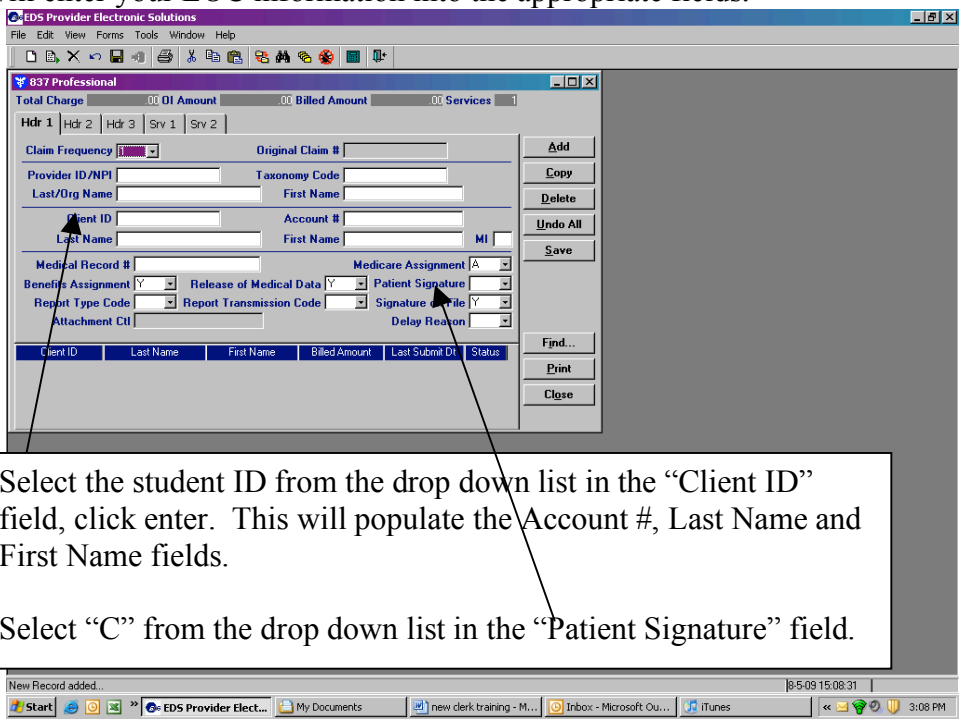
ENTERING ELECTRONIC CLAIM

With all of your lists created, you are ready to enter your claim.

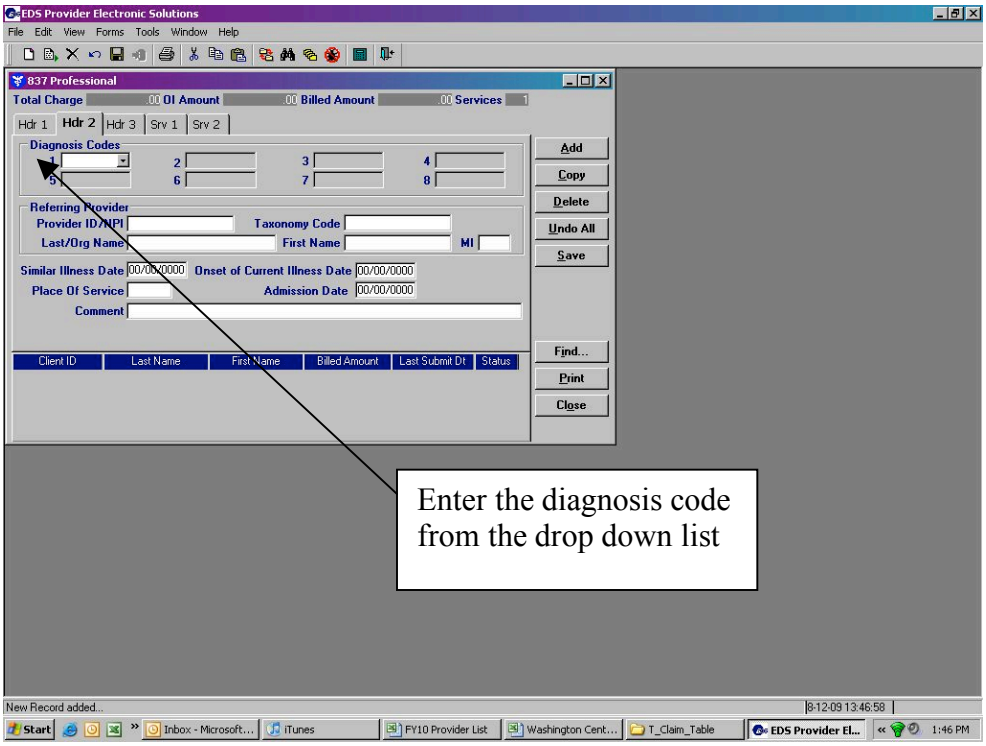


HDR 1 TAB

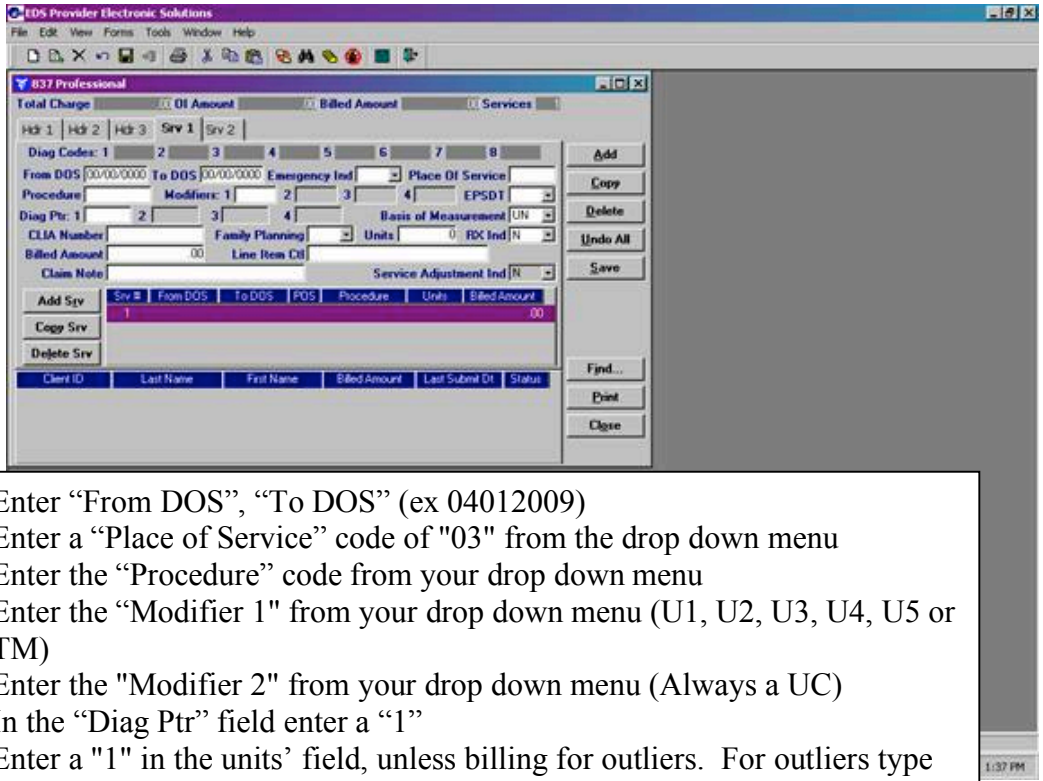
Now you will enter your LOC information into the appropriate fields.



HDR 2 TAB



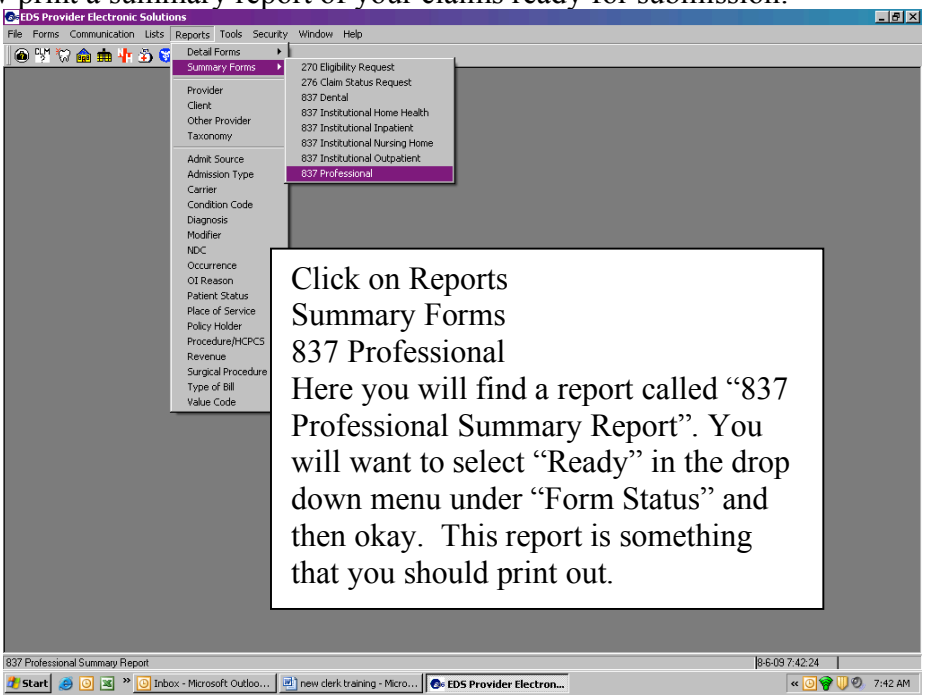
SRV 1 TAB



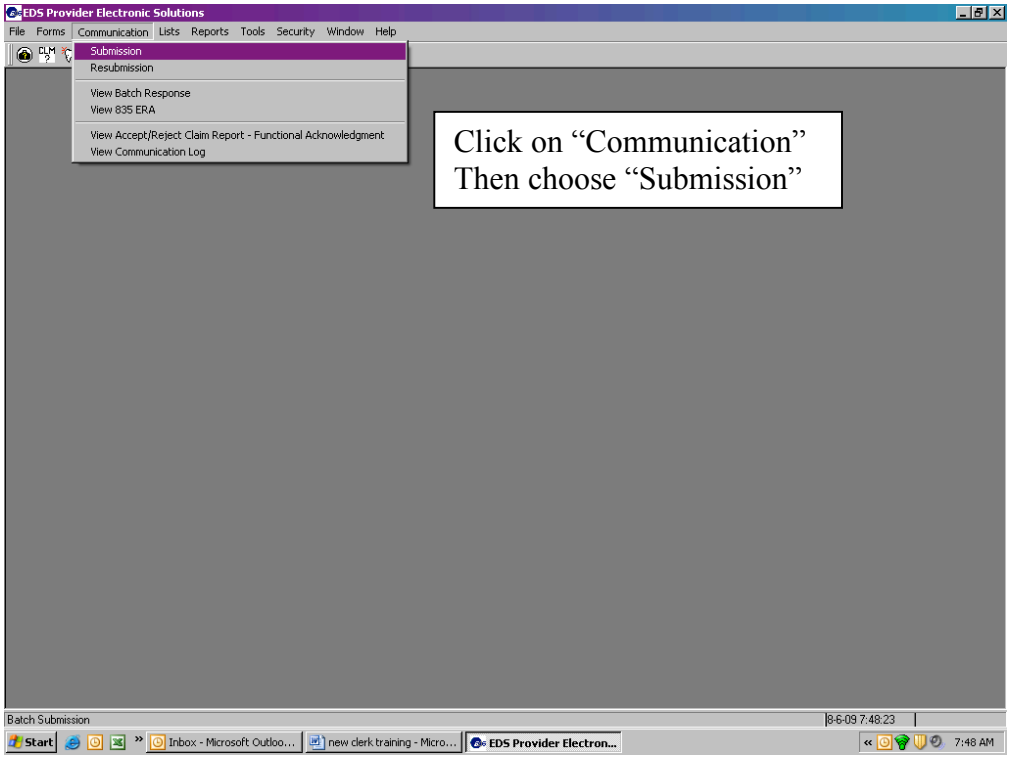
Enter “From DOS”, “To DOS” (ex 04012009)
Enter a “Place of Service” code of "03" from the drop down menu
Enter the “Procedure” code from your drop down menu
Enter the “Modifier 1" from your drop down menu (U1, U2, U3, U4, U5 or TM)
Enter the "Modifier 2" from your drop down menu (Always a UC)
In the “Diag Ptr” field enter a “1”
Enter a "1" in the units’ field, unless billing for outliers. For outliers type the number of outlier units.
Enter the $ amount of the claim and click SAVE. Now click ADD to continue

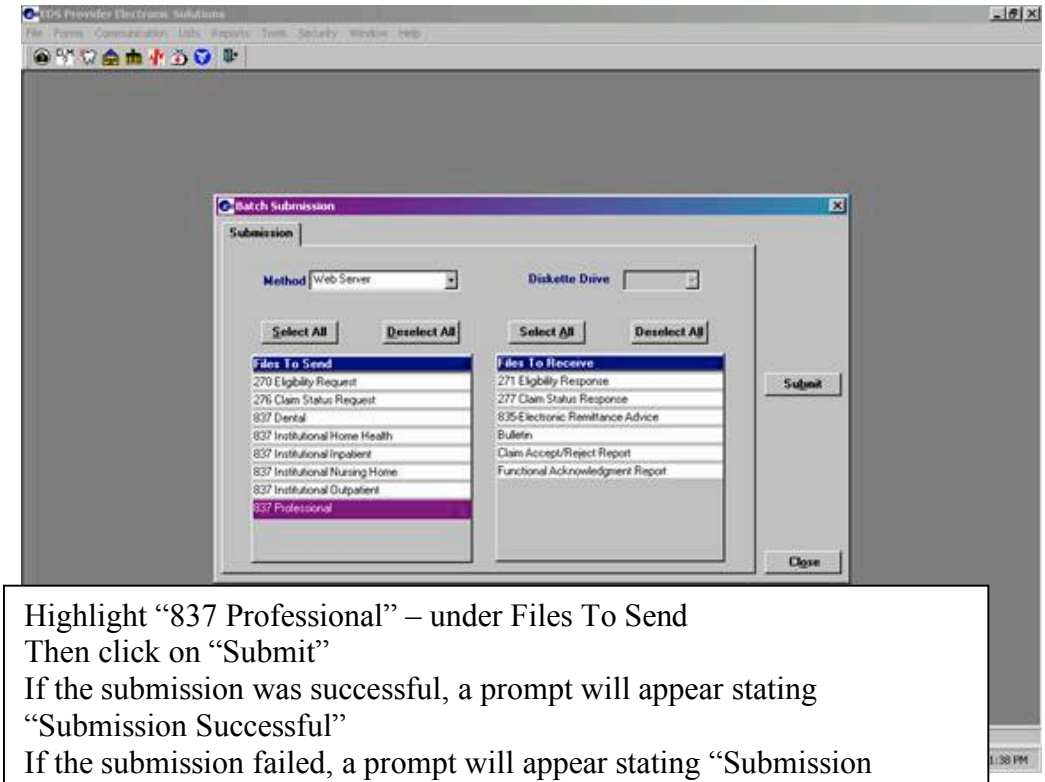
SUMMARY REPORT

You can now print a summary report of your claims ready for submission:



SUBMITTING CLAIMS





Highlight "837 Professional" – under Files To Send
Then click on "Submit"
If the submission was successful, a prompt will appear stating "Submission Successful"
If the submission failed, a prompt will appear stating "Submission Failed." In this case you will want to check the Communication Log to determine the cause of the failure. Your Field Representative can assist in understanding this report.

FUNCTIONAL ACKNOWLEDGEMENT/CLAIM ACCEPT REJECT

- Go to Communications
- Select Submission
- Highlight Claim Accept/Reject Report and Functional Acknowledgement Report under "Files to Receive"
- Click Submit
- You will receive the "Submission Successful" message
- Close that screen and click on Communications
- Highlight "View Accept/Reject Claim Report--Functional Acknowledgement"
- Open the "ack.ack" and the "sub.sub" files
    - Look for "A-Accepted" or "R-Rejected" about half way down the report. If it reads "A-Accepted" everything is fine. If it reads "R-Rejected" there was a problem with the claims.
    - There is information contained in this report that will tell you where the problem is.
    - Call your field representative if you need help in determining the problem. They will help you find the solution or follow up with EDS.

If you have any issues or questions with the billing software you should call your field representative.

REMITTANCE ADVICE

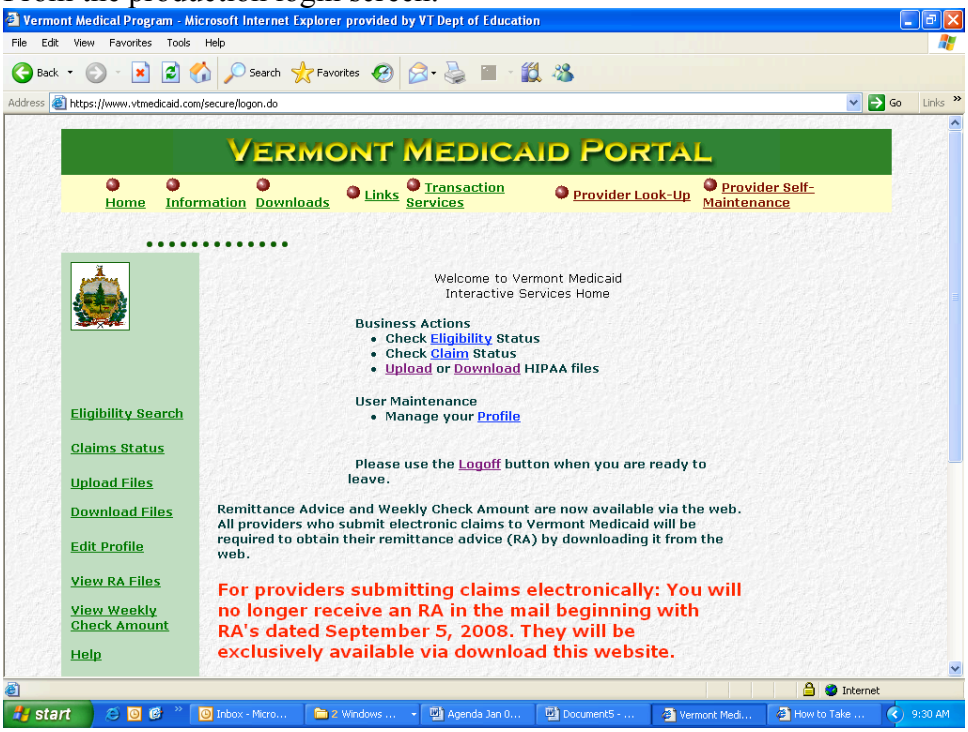
The Remittance Advice (RA) is a report of the status of all claims submitted for processing. This form is accessed at the www.vtmedicaid.com website. Only the four most recent RA's are available for viewing, so it is important to check for RA's weekly.

REVIEWING THE RA:

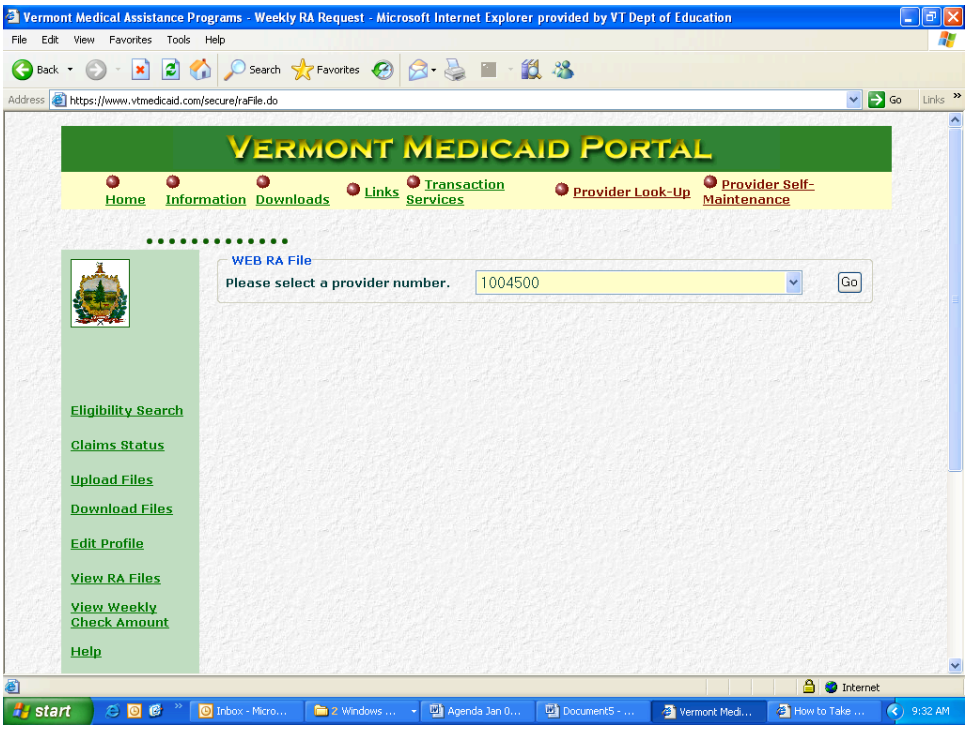
- Best practice is to compare submitted claims against the RA to determine which claims have been paid, suspended or denied
- The RA date can be noted on the paid claims and those claims can be filed
- Suspended claims will either pay or deny on a future RA
- Denied claims need to be reviewed to determine if the claim can be corrected and resubmitted. The denial codes are printed on the last page of the RA with an explanation of the code. If you are unable to determine the reason for the denial, contact your field representative.

VIEW REMITTANCE ADVICE

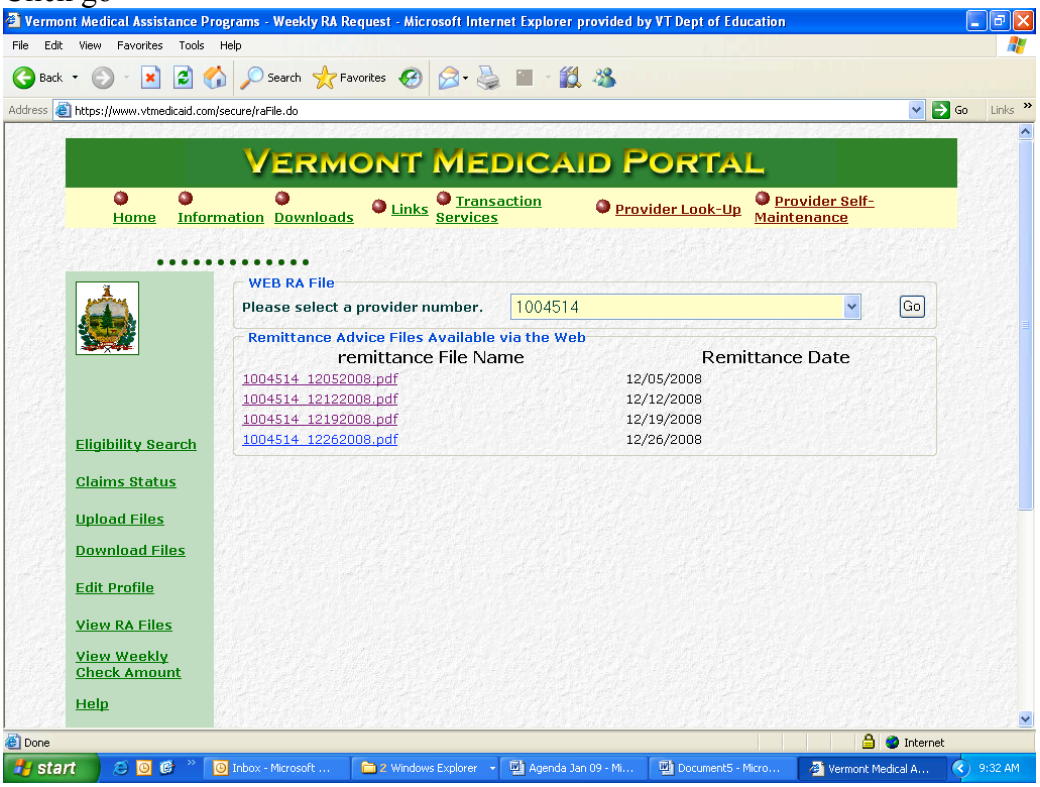
From the production login screen:



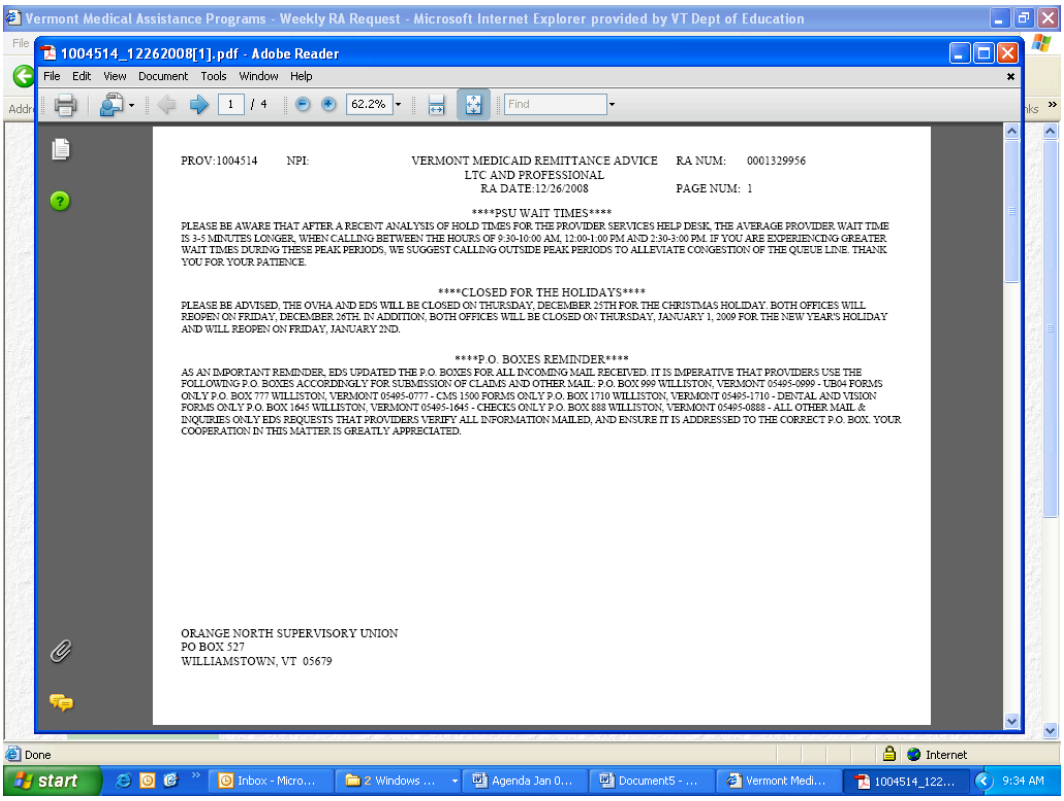
Select View RA Files



Click go



Click the Remittance Advice you would like to view. The four or five most recent RA's will be available to review.



The RA is a PDF file. It can be printed. It can also be saved for future reference.

ADJUSTMENTS/RECOUPMENTS

Adjustments and recoupments are used to correct or void claims that have already been paid. Please contact your field representative to determine if a claim needs to be adjusted or recouped and to receive help in properly processing the claim.

TIME FRAME:

- A positive financial adjustment can be completed up to one year after the date of the RA
- A negative financial adjustment can be completed up to three years electronically

PAPER TRAIL IN THE STUDENT'S MEDICAID FILE:
Paperwork documenting the reason for the adjustment/recoupment is needed for auditing purposes,. The following are acceptable forms of documentation

- A copy of the adjustment or recoupment page from the RA, with other student's names blacked out
- The original LOC clearly showing what adjustments were made, or a note stating the LOC was recouped
- A new LOC with a note stating the original LOC was adjusted
- A piece of paper stating that an adjustment or recoupment occurred for a certain billing period

PROCESS FOR ADJUSTMENTS:

- Open the 837 Professional claim form in the EDS billing software
- Go to Hdr 1 and click claim frequency
- In the drop down box, select "7 (Replacement)"
- In the "Original Claim #" box enter the ICN number from the RA that shows the claim was paid
- Enter the claim information the way the corrected claim **should read**
- Save and submit the new claim

PROCESS FOR RECOUPMENTS:

- Open the 837 Professional claim form in the EDS billing software
- Go to Hdr 1 and click claim frequency
- In the drop down box, select "8 (Void)"
- In the "Original Claim #" box enter the ICN number from the RA that shows the claim was paid
- Enter the claim information the way it was submitted
- Save and submit the new claim

GRANT AWARDS

The Department of Education will send each supervisory union a monthly grant award for any claims that have been paid during the previous month. The Grant Award will show a breakdown by school district of the grant amount, the State-Placed retained/ unretained amounts and additional SCHIP revenue.

A notification letter may be sent in lieu of a Grant Award. The following are the most common reasons a Grant Award or check are not generated:

- No RA's were generated during the month
- The amount of State-Placed funds retained or adjusted/recouped exceeded the amount of paid claims
- The Grant Award and check are held due to a missing or incomplete Medicaid Reinvestment Report or Health Services Report
- The Grant Award is generated but a check is not sent due to a missing Department of Education financial report or funds are held by the tax department

STATE PLACED STUDENTS

By definition, a State-Placed Student is placed in a school district other than the district of residence of either of his/her parents or legal guardian. The state pays for the education costs for State-Placed Students. Worksheet A of the Special Education Expenditure Report is the method used to claim reimbursement for special education services provided to State-Placed Students on IEP's.

Supervisory unions are strongly encouraged to file appropriate Medicaid claims within the filing deadline. This ensures that the school district receives their funding and the State receives the Medicaid funds needed to help pay State-Placed Student claims. The Department realizes that there are a number of reasons that might have prevented the supervisory unions from filing Medicaid claims for State-Placed Students. Therefore, there is the opportunity for supervisory unions to explain why the claims were not made and the possibility of eliminating any penalty. When submitting a justification letter please include the level of care the claim would have been billed at.

The current policy is that $1,000 of the State-Placed Student reimbursement requested on Worksheet A is held for each missing Medicaid claim. The State-Placed Student reimbursement held cannot exceed the amount claimed for the student as State-Placed Student reimbursement. An Attachment 5 will be sent to the Medicaid clerk showing the specific Medicaid claims missing for each of the students on Worksheet A.

OUT-OF-DISTRICT PLACEMENT

THERE ARE THREE TYPES OF OUT-OF-DISTRICT PLACEMENTS:

- When a Local Education Agency (LEA) pays tuition to send a student to a program operated by another public school.
- When a LEA pays tuition to send a student to a private school that has been approved by the Department of Education to offer special education services.
- When a student attends an out-of-district public school either because the district does not operate a school for their grade or due to school choice.

OUT OF DISTRICT PROVIDER CERTIFICATION AGREEMENT

When billing for out-of-district services Medicaid requires the provider documentation be on file at the sending school. By signing the Out-of-District form the receiving school acknowledges they have the required signatures and current licenses for their providers. A form needs to be completed each school year for each student.

SPECIAL EDUCATION PROGRAMS OPERATED WITHIN YOUR SU

Some Supervisory Unions operate programs outside of the regular education setting. You DO NOT need to have an out-of-district form for these billable students as the providers are paid through your supervisory union.

BILLING RIGHTS

Only the district of residence has the right to bill Medicaid.

RECORDS

SET-UP OF MEDICAID FILE

A Medicaid file needs to be maintained for each student eligible for the School Based Health Services Program. A complete Medicaid file contains the following:

- Release of Information
- Physician Authorization
- IEP and Reevaluation Claim Forms (pink and blue forms)
- The cover page and services page of the student's current IEP, including the consent paragraph.
- The completed LOC with copies of staff documentation attached to each LOC form and any other claim forms.
- Out-of-District Provider Certification Agreement (where appropriate)
- Progress Notes (where appropriate)

CONFIDENTIALITY

All staff who deals with the School-Based Health Services have access to a great deal of confidential information and need to be aware of the confidentiality laws pertaining to the information.

- FERPA - The Family Educational Rights and Privacy Act is a federal law that governs the disclosure of information contained in student records.
- HIPAA – The Health Insurance Portability and Accountability At of 1996 sets forth provisions for protecting the security, confidentiality, and privacy of health information.

RECORDS NEED TO BE AVAILABLE FOR FILE REVIEWS

Medicaid records are subject to audit. The records need to be available throughout the school year and during the summer. If the files are not kept in a central location such as the supervisory union office or at the schools, they must be made available within a reasonable time when requested.

RETENTION

- All the required documentation for Medicaid claims is to be kept for seven years, including
    - Release of Information
    - Physician Authorization
    - LOC/Eval/IEP claim forms
    - Documentation logs
    - Progress Notes
    - IEP's
    - Provider Certification and Licenses
    - Adjusted claim documentation
- It is recommended that the current student Medicaid file contain information for the current and prior school year

CREATING A TRACKING SYSTEM

Since there is a 6-month billing deadline, it is very important to develop a tracking system. This system needs to be developed by the Medicaid clerk because, what will work for one person may not work for another.

You should track:

- Medicaid eligible students
  - When eligible
  - If they go off Medicaid
  - If they move/exit
  - New students coming into the school district
  - Which case manager is responsible for the student
- Consents
  - Is the release of information signed
  - Is there a check on the related services page giving permission to bill Medicaid
- Physician Authorization
  - Has it been sent
  - Has it returned with a signature
  - When does it begin and end
  - When do you need to obtain a new physician authorization
- IEPs and 3-yr Evaluations
  - When is the next IEP due
  - When is the next 3-yr Evaluation due
  - Have you received them and billed them
- Documentation
  - What documentation logs you need
  - What documentation logs you have received
  - Is the documentation complete
  - What documentation logs have been returned to be corrected
  - Have the corrected logs been returned
  - Do you have progress notes when applicable
- Pre-Billing
  - Do you have a signed consent
  - Do you have a current physician authorization
  - Do you have a valid IEP cover sheet, service page, 5b, 7a or Sped Doc amendment form to cover the period being billed
  - Do you have completed documentation logs
  - Do you have provider certifications and licenses/appropriate documentation for all professional service providers that you are billing services for
- Billing
  - When claims were submitted
  - Did the claims pay
  - Were claims resubmitted, adjusted, recouped, etc

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MEDICAID ENROLLMENT INFORMATION

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